Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARK HACKBARTH MD
700 OLYMPIC PLAZA SUITE 850
TYLER TX 75701

Respondent Name
LIBERTY MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-07-2059-01

MFDR Date Received
NOVEMBER 28, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "2ND lead on stim is separately payable per Medicare. I have appealed 3 times to carrier & they still have not processed. Fax confirmations attached. It is well beyond the 21 days to pay an appeal."

Amount in Dispute: $238.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the dispute packet.

Response Submitted by: Coventry Health Care

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2006	CPT Code 63650-59	$238.85	$23.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97- Payment is included in the allowance for another service/procedure.
   - X815-This procedure is incidental to the primary procedure, and does not warrant separate reimbursement .
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - Z315-Payment is based on apportioned percentage.
   - 42- Charges exceed our fee schedule or maximum allowable amount.
   - W1-Workers compensation state fee schedule adjustment.
   - B7- Payment adjusted because this service was not prescribed by a physician, not prescribed prior to

delivery, the prescription is incomplete, or the prescription is not current.
- 17- Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.

Issues

Is the requestor entitled to additional reimbursement for CPT code 63650-59?

Findings

CPT code 63650 is defined as "Percutaneous implantation of neurostimulator electrode array, epidural."

The requestor used modifier 59 to identify a separate service.

Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the Operative report indicates that the claimant underwent "Dual spinal cord stimulator lead placement/trial." The Operative report also states that "two separate 14-gauge Tuohy needles were advanced under fluoroscopic guidance …two separate Medtronic octad spinal cord stimulator leads were advance, one through each needle"; therefore, the use of modifier -59 is supported.

28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75701, which is located in Smith County.

The Medicare allowable for code 63650 is $382.15.

The MAR for CPT code 63650-59 in Smith County is $477.68. This code is subject to multiple procedure discounting; therefore, $477.68 X 50% = $238.84. The respondent paid $214.97. As a result, the requestor is due $23.87.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $23.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $23.87 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		10/30/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.